PRN Medication Log Sheet

Long-Term Care Facility

Resident Name: _____

Room/Bed #: _____

Date of Birth: _____

Physician: _____

Medication Name: _____ Dose: _____ Route: _____

Reason for PRN: _____

Date	Time Given	Dosage	Reason Given	Effectiveness/Outcome	Staff Initials

Staff Signature/Initials:

_____

Date:

_____